Correspondence

Because of heavy pressure on our space, correspondents are asked to keep their letters short.

Future of the Tuberculosis Service

SIR,—In your leading article on the Joint Tuberculosis Council's *Report on the Future Service for Tuberculosis and Diseases of the Chest* (*Journal*, January 31, p. 286) you recommend that consideration be given to the closure of chest hospitals and sanatoria situated in rural areas and the building of chest units in the purlieu of general hospitals. General hospitals are of course usually situated in the centre of towns and cities. There is a certain connexion between atmospheric pollution and chest disease. Before deciding to liquidate first-class beds situated in green belts and rural areas it might be as well to consider the pathological status of some of the patients to be treated.

In the treatment of chronic bronchitis I have been able to observe the difference in results which can be obtained when such patients are treated in general medical wards and under modified sanatorium conditions in the country. The antibiotics achieve their temporary effect under both conditions, but the patient receives a more lasting benefit and stability under the latter. Asthmatics do not thrive in busy chest wards *vis-à-vis* respiratory failures. They are better treated in the tranquil cubicles of the rural sanatoria. Restoration of morale under good atmospheric conditions, a cheerful environment combined with sound physiotherapy and graded exercise, can even help advanced cases of emphysema. Perhaps readmission may be required the following winter, but experienced sanatorium staffs are not unaccustomed to relapse, and many respiratory cripples have more faith in environment than tetracycline.

A surgical colleague has assured me that cases of renal tuberculosis do far better under "sanatorium" than hospital conditions. I have been told, by those in a good position to know, that patients with peptic ulcers get worse in busy general wards, and I have been asked to treat them in the relative peace of rural sanatorium beds. A gastro-enterologist has asked me to treat his cases of ulcerative colitis away from the comparative turmoil of his general hospital milieu. A cardiologist would have me admit his recovering cases of coronary thrombosis to the controlled and experienced regime of graded mobilization obtainable in sanatoria.

It is strange, Sir, that some of my colleagues profess to regard the sanatorium as unsuitable for the treatment of pulmonary tuberculosis, and demand that new units (or even old dumps) should be used for this purpose under their personal care. In the headlong flight from an essential specialty to integration with general medicine, it is to be hoped that conditions of service for doctors will not always prejudice conditions of treatment for patients.—I am, etc.,

Harefield Hospital, Middlesex. L. E. HOUGHTON.

Immunization Programmes

SIR,—Dr. M. Adams and his colleagues (*Journal*, February 7, p. 362) have suggested an immunization programme and asked for criticism of their scheme. Theirs is only one of many schemes which have been proposed in theory or put into practice. Last year, my colleagues and I (*Journal*, January 4, 1958, p. 39) drew attention to the confusion that exists on this subject, and put in a plea for a national policy. If these schemes are to be discussed it seems to be worth considering their aims.

The first and obvious aim to-day is to immunize as many infants as possible against whooping-cough, diphtheria, poliomyelitis, tetanus, and smallpox. The second aim is to give the various injections early enough to protect the young infant, yet not so early that antibody formation is likely to be incomplete. The third aim is to give the injections in the form least likely to injure the child.

In practice this means giving whooping-cough immunization very early, as Dr. E. C. H. Huddy suggests (*Journal*, January 31, p. 303), but it may mean delaying immunization against diphtheria and smallpox[1] until the age of 6 months; and it means that there is an added danger of precipitating poliomyelitis if certain vaccines are combined.

Scientifically, then, the ideal scheme must be one in which the antigens are given singly, and not in combination. This at once avoids the added risk of poliomyelitis inherent in combined vaccines, and allows one to choose the optimum age for each immunizing agent. There might be some argument about the exact order, but probably it would be whooping-cough first, then poliomyelitis, smallpox, diphtheria, and tetanus.

Why, therefore, should there be any question of combined vaccines at all? The answer, of course, is: (1) To reduce the number of attendances imposed on infants and parents. (2) To reduce the amount of injection-induced terror of doctors that the infants are likely to acquire. (3) To simplify the scheme so that everyone does not get into a hopeless muddle about what injections have been given, and what injections are yet to come. There is no doubt that the simpler the scheme the more likely it is to be completed in the greatest number of children. From these points of view the ideal would be to give all the immunizing agents together in the smallest possible number of injections, if that were feasible, and get the whole thing over as quickly as possible.

Now the first thing is to decide whether or not these considerations are sufficiently important to modify the scientifically ideal programme of immunization. Personally, I think they are, and I think there must be some combination of vaccines, but this means that there must be a compromise between a socially desirable scheme and the scientific ideal. It is probably impossible to use combined vaccines, and yet to give all the immunizing agents in the safest form at the ideal time for each and every one. Unless the nature of this compromise is clearly realized there is bound to be a lot of fruitless discussion on immunization programmes. If the necessity for compromise is accepted, then the only argument is how many antigens can be combined to give a reasonably safe and efficient vaccine, and what is the best age to give it.—I am, etc.,

Wantage, Berks. I. S. L. LOUDON.

REFERENCE

[1] Galloway, W. H., and MacBean, L. M., *Brit. med. J.*, 1958, **2**, 490.

The Influenza Epidemic

SIR,—We wonder if this epidemic of so-called influenza really is influenza. We notice that, unlike the previous epidemics, whole families are affected at the same time and not one after the other; also there is a high incidence of frontal headaches, pains in the chest (usually left side), pleuritic in type, and high fever 103–104° F. (39.4–40° C.) and abdominal discomfort, with diarrhoea in some cases and more frequent relapses.

These signs suggest to us that this is an epidemic suggestive of Bornholm disease.—We are, etc.,

R. G. WIGODER.

London, S.E.6. H. G. JEFFS.